# Physical Therapy Protocol Checklist

**Service Recipient's Name** _____ **Date of Birth** _____
(Last, First)

**Reviewer's Name** _____ **Date Request Submitted** _____
(Last, First)

## Technical Review

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| ☐ **YES** ☐ **NO** | Is the correct funding source, site code, and service code used in Section C of the Individual Support Plan?<br><br>If **YES**, continue to Question #1 in Section A, B, or C as applicable.<br><br>If **NO** and the wrong funding source, site code and service code is due to a simple error, correct the error and continue to Question #1 in Section A, B, or C as applicable.<br><br>If **NO** based on lack of a site code because the provider is not licensed or does not have an approved provider agreement, deny as non-covered due to failure to meet provider qualifications as specified in the waivers and in the TennCare rules applicable to the waivers. |

## A. Initial Request for Physical Therapy Assessment

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| **1.** ☐ **YES** ☐ **NO** | Is the service recipient age 21 years or older? (A.1)<br><br>If **YES**, proceed to Question #2.<br><br>If **NO**, skip to Question #9. |
| **2.** ☐ **YES** ☐ **NO** | Is this a new assessment for Environmental Accessibility Modifications (i.e., home modifications)? (A.2)<br><br>If **YES**, skip to Question #7.<br><br>If **NO**, proceed to Question #3. |
| **3.** ☐ **YES** ☐ **NO** | Is the assessment needed in order to determine the need for treatment of a medical condition or functional deficit involving ambulation and mobility that is related to an injury, illness, or hospitalization occurring within the past 90 days? (A.3)<br><br>If **YES**, proceed to Question #4.<br><br>If **NO**, skip to Question #5. |
| **4.** ☐ **YES** ☐ **NO** | Was a request for a Physical Therapy assessment denied through the TennCare MCO fair hearing process and, if applicable, denied or not covered by Medicare? (A.4)<br><br>If **YES**, proceed to Question #5. |

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| | If **NO**, stop and deny based on the waiver being the **payor of last resort**, unless the service recipient is currently receiving waiver-funded PT and is requesting all of the PT to be provided through the waiver by the same provider. If the latter, proceed to Question #5. Otherwise, deny. |
| **5.** ☐ **YES** ☐ **NO** | Is the request for an initial assessment after enrollment in the waiver or after an interval of at least 12 months since the last Physical Therapy assessment? (A.5)<br><br>If **YES**, skip to Question #7.<br><br>If **NO**, proceed to Question #6. |
| **6.** ☐ **YES** ☐ **NO** | Is a new Physical Therapy assessment needed because: (A.6)<br><br>a. The service recipient was discharged from services by a physical therapist who discontinued being a waiver services provider; **OR**<br><br>b. The service recipient is currently receiving waiver-funded PT and has now developed an acute need for additional services to restore lost function. Such additional services would normally be provided by the MCO, but to ensure coordination, all of the PT will be provided through the waiver by the same provider.<br><br>If **YES**, proceed to Question #7.<br><br>If **NO**, skip to Question #8. |
| **7.** ☐ **YES** ☐ **NO** | Medical necessity review questions: (A.7)<br><br>a. Is there an order by a physician, physician assistant, or nurse practitioner for the Physical Therapy assessment; **AND**<br><br>b. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient has a medical diagnosis or functional deficit involving ambulation and mobility; **AND**<br><br>c. Is there sufficient information in the Individual Support Plan (ISP) to conclude that, based on the service recipient's medical diagnosis or functional deficit involving ambulation and mobility, the service recipient's functional and/or treatment needs cannot be adequately determined without a new Physical Therapy assessment?<br><br>If **YES** to all three of the criteria specified in "7.a" through "7.c" above, skip to Question #11.<br><br>If **NO** to any criterion specified in "7.a" through "7.c" above, stop and deny as **not medically necessary.** |
| **8.** ☐ **YES** ☐ **NO** | Medical necessity review questions: (A.8)<br><br>a. Is there an order by a physician, physician assistant, or nurse practitioner for the Physical Therapy assessment; **AND**<br><br>b. Is there sufficient information in the Individual Support Plan (ISP) to document that:<br><br>(1) The service recipient has a new medical diagnosis or functional deficit |

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| | involving ambulation and mobility; **OR**;<br><br>(2) The service recipient has experienced a significant exacerbation of a pre-existing medical condition or functional deficit after having been discharged from Physical Therapy services by the physical therapist; **AND**<br><br>c. Is there sufficient information in the Individual Support Plan (ISP) to conclude that, based on the service recipient's medical diagnosis or functional deficit involving ambulation and mobility, the service recipient's functional and/or treatment needs cannot be adequately determined without a new Physical Therapy assessment?<br><br>If **YES** to all three of the criteria specified in "8.a" through "8.c" above, skip to Question #11.<br><br>If **NO** to any criterion specified in "8a" through "8c" above, stop and deny as **not medically necessary**. |
| **9.** ☐ **YES** ☐ **NO** | Is this a new assessment for Environmental Accessibility Modifications (i.e., home modifications)?<br><br>If **YES**, proceed to Question #10.<br><br>If **NO**, stop and deny based on the waiver being the **payor of last resort**. |
| **10.** ☐ **YES** ☐ **NO** | Medical necessity review questions: (A.10)<br><br>a. Is there an order by a physician, physician assistant, or nurse practitioner for the Physical Therapy assessment; **AND**<br><br>b. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient has a medical diagnosis or functional deficit involving ambulation and mobility; **AND**<br><br>c. Is there sufficient information in the Individual Support Plan (ISP) to conclude that, based on the service recipient's medical diagnosis or functional deficit involving ambulation and mobility, the service recipient's functional and/or treatment needs (in the case of a child under age 21, the need for environmental accessibility modifications) cannot be adequately determined without a new PT assessment?<br><br>If **YES** to all three of the criteria specified in "10.a" through "10.c" above, proceed to Question #11.<br><br>If **NO** to any criterion specified in "10.a" through "10.c" above, stop and deny as **not medically necessary.** |
| **11.** ☐ **YES** ☐ **NO** | Has the waiver limit of three (3) PT assessments per waiver year per provider been exceeded? (A.11.)<br><br>If **YES**, deny as a **non-covered service** based on the waiver service limit of three (3) assessments per service recipient per provider per program year.<br><br>If **NO**, stop and approve the assessment. |
| ☐ **Approved** | |
| ☐ **Denied** | |

## B. Initial Physical Therapy Services (excluding assessment)

Note: This section applies to service recipients who are not currently approved for Physical Therapy services through the waiver.

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| **1.** ☐ **YES** ☐ **NO** | Is the service recipient age 21 years or older? (B.1)<br><br>If **YES**, proceed to Question #2.<br><br>If **NO**, stop and deny based on the waiver being the **payor of last resort**. |
| **2.** ☐ **YES** ☐ **NO** | Is Physical Therapy needed in order to restore lost function due to a medical condition or functional deficit involving ambulation and mobility that is related to an injury, illness, or hospitalization occurring within the past 90 days? (B.2)<br><br>If **YES**, proceed to Question #3.<br><br>If **NO**, skip to Question #4. |
| **3.** ☐ **YES** ☐ **NO** | Was a request for Physical Therapy denied through the TennCare MCO fair hearing process and, if applicable, denied or not covered by Medicare? (B.3)<br><br>If **YES**, proceed to Question #4.<br><br>If **NO**, stop and deny based on the waiver being the **payor of last resort**. |
| **4.** ☐ **YES** ☐ **NO** | Medical necessity review questions: (B.4)<br><br>a. Is there an order by a physician, physician assistant, or nurse practitioner for the Physical Therapy; **AND**<br><br>b. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient has a medical diagnosis or functional deficit involving ambulation and mobility; **AND**<br><br>c. Is there sufficient information in the ISP and/or supporting documentation (e.g., the therapy plan of care) to conclude that the service recipient's functional and/or treatment needs involving ambulation and mobility cannot be adequately met unless Physical Therapy is provided by a licensed physical therapist or physical therapy assistant working under the supervision of a licensed physical therapist (i.e., paid and unpaid caregivers would not otherwise be able to adequately meet the specified functional or treatment needs); **AND**<br><br>d. Is there sufficient documentation in the ISP and/or supporting documentation to conclude that the provision of Physical Therapy services can be reasonably expected to 1) achieve measurable and sustained functional gains for the service recipient; 2) maintain current functional abilities that would be lost without the provision of Physical Therapy Services; or 3) prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent development of serious medical problems); **AND**<br><br>e. Are there clearly defined measurable Physical Therapy goals in the ISP and/or supporting documentation which are reasonable and appropriate given the person's current age and health status? |

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| | If **YES to all five** of the criteria specified in "4.a" through "4.e" above, proceed to Question #5.<br><br>If **NO** to any criterion specified in "4.a" through "4.e" above, stop and deny as **not medically necessary.** |
| **5.** ☐ **YES** ☐ **NO** | Is the frequency (per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of Physical Therapy Services requested consistent with and not in excess of the amount of services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "4.d" above? (B.5)<br><br>NOTE: To the maximum extent possible and appropriate, Physical Therapy Services by a licensed physical therapist or licensed physical therapy assistant working under the supervision of a licensed physical therapist should be utilized to develop a treatment plan that can be implemented by caregivers (including, but not limited to family members, paid personal assistants, and residential services staff), across activities and settings in order to achieve the maximum therapeutic benefit. Periodic services by the licensed physical therapist or licensed physical therapy assistant working under the supervision of a licensed physical therapist should be authorized only as necessary to support the ongoing implementation of the treatment plan, or to modify the treatment plan in response to the changing needs of the service recipient..<br><br>If **YES**, stop and approve the amount of Physical Therapy Services requested. Such approval may specify that concurrent review will be conducted after a specified period of time (see attached guidelines) to ensure that Physical Therapy Services continue to be medically necessary. Such determination shall be based on current medical records provided by the licensed professional and/or physician, physician assistant, or nurse practitioner in response to the request for concurrent review.<br><br>If **NO**, approve that portion of the total amount of Physical Therapy Services requested that is consistent with the amount of Physical Therapy Services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "4.d" above. Deny as **not medically necessary** that portion of the total amount of Physical Therapy Services requested that is in excess of the amount of services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "4.d" above. |
| ☐ **Approved** | |
| ☐ **Denied** | |

## C. Continuation Physical Therapy Services (excluding assessment)

Note: This section applies to service recipients who are currently approved for Physical Therapy through the waiver and who request continuation of Physical Therapy or an increase in Physical Therapy.

To ensure coordination of ongoing services, if a service recipient age 21 and older is already receiving waiver funded Physical Therapy services and also develops an acute need for additional Physical Therapy services in order to restore lost function that would otherwise be provided by the MCO, the additional Physical Therapy services may be approved through the waiver if medically justified, so that all of the Physical Therapy services would be provided through the waiver by the same provider).

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| **1.** ☐ **YES** ☐ **NO** | Is the service recipient age 20 years or older? (C.1)<br><br>NOTE: If a service recipient is age 20 years (but not yet age 21), transition of Physical Therapy Services to the TennCare MCO will not be initiated since transition back to waiver services would likely be required upon attaining 21 years of age.<br><br>If **YES**, skip to Question #3.<br><br>If **NO**, proceed to Question #2. |
| **2.** ☐ **YES** ☐ **NO** | Is the request for an increase in the frequency (per week, per month, etc) or amount (# of units) of Physical Therapy Services? (C.2)<br><br>If **YES**, **deny** the requested increase in the frequency or amount of Physical Therapy Services based on the waiver being the **payor of last resort**. **Approve** the **continuation** of Physical Therapy Services at the current level pending transition of medically necessary Physical Therapy Services to the TennCare MCO.<br><br>If **NO, or upon denial of a requested increase** in the frequency or amount of Physical Therapy Services as noted above, initiate the process for transition of **all** medically necessary Physical Therapy Services to the TennCare Managed Care Organization (MCO). |
| **3.** ☐ **YES** ☐ **NO** | Medical necessity review questions for continuation of the currently approved level of Physical Therapy Services for an adult service recipient age 20 or older plus any requested increase in such services, as applicable: (C.3)<br><br>a. Is there an order by a physician, physician assistant, or nurse practitioner for the Physical Therapy; **AND**<br><br>b. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient continues to have a medical diagnosis or functional deficit involving ambulation and mobility; **AND**<br><br>c. Is there sufficient information in the ISP and/or supporting documentation (e.g., the therapy plan of care) to conclude that the service recipient's functional and/or treatment needs involving performance of ambulation and mobility still cannot be adequately met unless Physical Therapy Services are provided by a licensed physical therapist or licensed physical therapy assistant working under the supervision of a licensed physical therapist (i.e., paid and unpaid caregivers would still not otherwise be able to adequately meet the specified functional or treatment needs); **AND**<br><br>d. Is there sufficient information in the ISP and/or supporting documentation to demonstrate:<br><br>(1) Progress toward defined treatment goals in terms of measurable and sustained functional gains for the service recipient that can be generalized to settings outside the immediate treatment environment; **OR**<br><br>(2) The continuing medical need for Physical Therapy Services in order to maintain current functional abilities that would be lost without the continued provision of Physical Therapy Services; **OR**<br><br>(3) The continuing medical need for Physical Therapy Services in order to prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent |

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| | development of serious medical problems?<br><br>e. Are clearly defined measurable Physical Therapy Services goals as specified in the ISP and/or supporting documentation still reasonable and appropriate given the person's current age and health status?<br><br>If **YES** to all five (5) criteria specified in "3.a" through "3.e" above, proceed to question 4**.**<br><br>If **NO** to any criterion specified in "3.a" through "3.e" above, stop and deny as **not medically necessary.** |
| **4.** ☐ **YES** ☐ **NO** | Is the frequency (per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of continued Physical Therapy Services requested plus any requested increase in such services, as applicable, consistent with and not in excess of the amount of services still needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "3.d" above? (C.4)<br><br>To the extent that the request includes any increase in the frequency, amount, or duration of Physical Therapy Services, is there sufficient information in the ISP and/or supporting documentation to demonstrate that the service recipient's needs have changed and/or the previously approved frequency, amount, or duration of Physical Therapy Services is no longer sufficient to (a) achieve measurable and sustained functional gains for the service recipient that can be generalized to settings outside the immediate treatment environment; (b) maintain current functional abilities that would be lost without the continued provision of Physical Therapy Services; or (c) prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent development of serious medical problems?<br><br>NOTE: To the maximum extent possible and appropriate, Physical Therapy Services by a licensed physical therapist or licensed physical therapy assistant working under the supervision of a licensed physical therapist should be utilized to develop a treatment plan that can be implemented by caregivers (including, but not limited to family members, paid personal assistants, and residential services staff), across activities and settings in order to achieve the maximum therapeutic benefit. Periodic services by the licensed physical therapist or licensed physical therapy assistant working under the supervision of a licensed physical therapist should be authorized only as necessary to support the ongoing implementation of the treatment plan, or to modify the treatment plan in response to the changing needs of the service recipient.<br><br>If **YES**, stop and approve the continuation of Physical Therapy Services and any increase as requested. Such approval may specify that concurrent review will be conducted after a specified period of time (see attached guidelines) to ensure that Physical Therapy Services continue to be medically necessary. Such determination shall be based on medical records provided by the licensed professional and/or physician, physician assistant, or nurse practitioner in response to the request for concurrent review.<br><br>If **NO**, approve that portion of the total amount of Physical Therapy Services requested that is consistent with the amount of Physical Therapy Services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "3.d" above.<br><br>If the request for Physical Therapy Services was submitted as an ISP amendment or as an annual update of the ISP, deny as **not medically necessary** that portion of the total amount of Physical Therapy Services requested that is in excess of the amount |

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| | of Physical Therapy Services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "3.d" above; **OR**<br><br>If the protocol was used for a DMRS-initiated review of an ISP and cost plan (i.e., rather than review of an ISP amendment or annual ISP update), issue 20 days advance notice (inclusive of mail time) of reduction or termination of services, as applicable, indicating that the services will be reduced or terminated on the 21st day from the date of the notice. The previously approved Physical Therapy Services shall continue to be authorized and reimbursed pending such advance notice period. |
| ☐ **Approved** | |
| ☐ **Denied** | |